

January 17, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0524-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed D.O. with a specialty and board certification in Neurological Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

After a work-related injury, ___, a 60-year-old female, complains of low back pain and pain down into the right leg. She has undergone physical therapy; epidural steroids which gave her no improvement; subsequent MRI and CT myelogram scanning. She has also seen ___, occupational medical specialist, and ___.

An MRI was done and it did show a small superimposed right paracentral disc protrusion at L4/L5 with associated disc bulge and facet arthrosis and also right-sided lateral disc bulge at L5/S1. A myelogram really did not suggest significant nerve root entrapment on the myelogram CT scan.

Her physical examination, according to the ___, showed right-sided pain in the leg itself, numbness into the foot, positive straight leg raising at 70 degrees, weakness of the extensor hallucis longus on the right, as well as diminished plantar strength on the right compared to the left. This was confirmed by the requesting surgeon.

REQUESTED SERVICE

Under dispute is the medical necessity of the proposed L4/L5, L5/S1 Right Discectomy.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds adequate documentation in favor of the requested L4/L5, L5/S1 Right Discectomy. The MRI is consistent with that. The myelogram CT scan does not quite show nerve root entrapment, at least according to the records provided, however the reviewer finds the MRI evidence to be sufficient. Also, there is adequate documentation by another physician who is independent of the surgeon. This is consistent with good medical care.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).